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Senate

The Senate met at 9:30 a.m., and was called to order by the President pro tempore [Mr. THURMOND].

PRAYER

The Chaplain, Dr. Lloyd John Ogilvie, offered the following prayer:

Today, on Abraham Lincoln's birthday, we remember some of the most powerful things he said about prayer. ''I have been driven many times to my knees,'' he said, ''by the overwhelming conviction that I had nowhere to go but to prayer. My own wisdom and that of all about me seemed insufficient for the day.'' When asked whether the Lord was on his side, he responded, ''I am not at all concerned about that, for I know that the Lord is always on the side of the right. But it is my constant anxiety and prayer that I—and this nation—should be on the Lord's side.''

Let us pray. Holy, righteous God, so often we sense that same longing to be in profound communion with You because we need vision, wisdom, and courage no one else can provide. We long for our prayers to be an affirmation that we want to be on Your side rather than an appeal for You to join our cause. Forgive us when we act like we have a corner on truth and our prayers reach no further than the ceiling. In humility, we spread our concerns before You and ask for Your marching orders and the courage to follow the cadence of Your drumbeat. Through Him who taught us to pray, ''Your will be done on Earth as it is in heaven.'' Amen.

RECOGNITION OF THE ACTING MAJORITY LEADER

The PRESIDENT pro tempore. The able acting majority leader, Senator NICKLES, is recognized.

Mr. NICKLES. Mr. President, the Senate pro tempore, thank you very much.

THANKING THE CHAPLAIN

Mr. NICKLES. Mr. President, I want to thank our Chaplain again for a beautiful opening prayer and excellent way to start a day which I believe is going to be a beautiful day.

SCHEDULE

Mr. NICKLES. Mr. President, this morning the Senate will be in a lengthy period of morning business through the hour of 2 p.m. for a number of Senators to speak. Following morning business, the Senate may proceed to any legislative or executive business cleared for action. Therefore, votes are possible during today's session of the Senate. As always, announcement will be made as soon as any rollcall votes are scheduled. As previously stated by the majority leader, there will be no rollcall votes during Friday's session of the Senate. I thank all Senators for their attention.

MORNING BUSINESS

The PRESIDING OFFICER (Mr. SANTORUM). Under the previous order, there will now be a period for the transaction of morning business not to extend beyond the hour of 2 p.m. with Senators permitted to speak for not to exceed 10 minutes each.

Under the previous order, the Senator from Oklahoma is recognized to speak for up to 20 minutes.

The Senator from Oklahoma.

Mr. NICKLES. Mr. President, thank you very much.

HEALTH CARE QUALITY

Mr. NICKLES. Mr. President, I want to make some statements dealing with health care. There has been a lot of discussion on health care and improving the quality of health care. Some of our colleagues have introduced legislation dealing with the quality of health care. I think that is important. But I think it is also very important that we actually improve quality, not improve the number of regulations.

Today, Mr. President, Americans enjoy the highest quality of health care in the world.

In 1993, President Clinton proposed a plan that would have devastated health care quality. It would have limited the amount of health care that Americans could receive by limiting the amount of money, whether private or public, that could be spent on health care services. It would require that everyone have the same one-size-fits-all package of health insurance benefits. And it would have enrolled everyone in managed care plans.

Had President Clinton had his way, Americans would now be trapped in a health care system with the efficiency of the post office and the compassion of the IRS at Pentagon prices. The Republicans led the fight against President Clinton's health care plan because we believe Americans deserve the best. We believed it then and we believe it today.

Now President Clinton wants to lead an assault on private managed care plans. The man who wanted to put everyone in an HMO now wants the Government to wage war on HMOs. That is a pretty dramatic change. But one thing has not changed: President Clinton still wants Government-run health care. As he said to the Service Employees International Union less than 5 months ago regarding his rejected universal health care program:

> If what I tried before won't work, maybe we can do it another way. That's what we've tried to do, a step at a time, until we eventually finish this.

President Clinton is now attempting to impose on you his newest attempt at Government-run health care and masking his efforts with the name ''quality.''

● This "bullet" symbol identifies statements or insertions which are not spoken by a Member of the Senate on the floor.

Mr. President, Republicans want only the highest quality health care. But I have not seen anything to convince me that bigger Government, more regulations, and expanded bureaucratic control is the means to higher quality.

Look at just one example of Government-controlled health care: The Medicare system. I am a member of the Finance Committee, the tax-writing committee of the Senate. We have been looking at the IRS and its treatment of taxpayers. There are 12,000 pages that deal with tax policy. I might mention, that is about 10 times the size of the Bible and, unlike the Bible, has no good news.

Well, there are 12,000 pages dealing with tax policies. That is a lot. But, Mr. President, do you know how many pages govern Medicare? Forty-five thousand, about four times as much as we have on tax policy. That comes from Dr. Robert Waller, the Mayo Clinic, Health Care Leadership Council. Forty-five thousand pages, yet the system is archaic, inefficient, and on the path of bankruptcy despite astronomical tax increases.

We know many people have believed they were denied coverage that their plans were supposed to cover. We recognize that some individuals fear that their health care plans will not give them access to specialists when they need them. We know that some Americans think their health care plans care more about cost than they do about quality. These are real fears of unacceptable conditions. We must do better. I think we can do better.

But the way to do better is not by politicizing health care quality or entrusting Government bureaucrats with policing health insurers. The way to do better is to emphasize what makes our system the best in the world—employers who insist their employees have access to the best plans, doctors and hospitals who aspire to excellence, and informed consumers who will not settle for anything less than the best. Quality health care cannot be managed and directed from Washington, DC.

Unfortunately, Mr. President, in the rush to respond to both real and perceived problems in managed care, members of both parties have introduced comprehensive proposals which potentially threaten—not enhance—the quality of health in our health care system.

Some of my colleagues may ask how I can make such a statement. You only have to look back to the end of the 104th Congress to illustrate my point. A majority of Congress supported an effort last year to mandate that all insurance plans cover 48-hour maternity stays in hospitals. Many of my colleagues on both sides of the aisle felt that it was socially unacceptable to discharge newborns and mothers from the hospital after only 24 hours and crafted legislation largely around social opinion.

Many Members felt great about voting for something positive for women and children. However, several months following the passage of that legislation an article appeared in the Journal of the American Medical Association. And here is what the clinical researchers and physicians had to say about what Congress accomplished.

> While the spirit of the current legislation may be laudable, its content does not solve the most important problems regarding the need for early postpartum/postnatal services.
>
> The legislation may give the public a false sense of security. It may call into question the reasonableness of relying on legislative mechanisms to micromanage clinical practice.
>
> Good clinical judgment, based on careful consideration of available evidence, suggests that the difference between a postpartum stay of 24 hours and a stay of 48 hours is unlikely to be a critical determinant of newborn or maternal health outcomes.

In other words, Congress made a nice, laudable attempt. We said we are going to mandate 48 hours, but it has had no appreciable improvement on the quality of health care.

It appears that our so-called victory in passing 48 hours may have in fact done more harm than good in helping women and newborns. This experience, and others like it, should have taught us what not to do. So what should our guiding principles be? I believe that there are three.

Whatever the proper role for Government in the health care debate, we must assure that it does not increase health insurance premiums, reduce the number of people who have health insurance coverage, or create massive new bureaucracies that will harm health care quality.

Why are these things important? Well, let us take a look at cost. We have a bill pending in Congress—the Patients Access to Responsible Care Act—and that is a pretty nice title. It is one of many that attempts to address health care by expanding Government control. But a recent study concluded that provisions in that bill alone would raise premiums by an average of 23 percent. That was done last year, 1997, by Milliman and Roberts.

Let us take a look at what that means. To the average family, that is an increase of about $1,220 per year. That is over $100 per month. That is real money. And I think a lot of families cannot afford that.

Cost is a very real issue. We do not want health care costs and prices to rise. We already know from the Congressional Budget Office that without any additional regulations at all, the growth in private health care premiums will be about 5.5 percent in 1998. That is up from 3.8 percent in 1997. So why in the world would we want to do anything that would accelerate the increase? I do not think we should.

No. 2, we do not want to do anything that will drive people from health insurance.

For a long time we have heard people beat up employers for not offering health care to their employees. But what are the facts? Well, someone looked into it and now we know that more employers than ever are offering health insurance. The problem is that employees are choosing not to take advantage of it because of cost. That came out from a study in 1997 by Cooper and Schone.

A separate study concludes that every 1 percent increase in private health insurance premiums results in 400,000 additional uninsured Americans. That was from a 1997 Lewin study. So, 400,000 additional uninsured Americans every time health insurance premiums increase 1 percent in real terms.

Now, wait a minute. If the PARCA bill—the Patient Access to Responsible Care Act—is estimated to increase costs by 23 percent, and every one of those percentage points equals 400,000 additional uninsured Americans, my calculations work that out to over 9 million Americans would lose their health insurance.

Mr. President, we do not want to do that. That may not be sound science, but the potential for such an outcome would be a disaster. It is too big of a gamble, in my opinion. Higher prices and more uninsured Americans does not sound like better health care quality to me. So let us not do that.

Thirdly, and finally, we want to make sure that the very best entity is monitoring the health care industry. And what are the options?

Many in Congress seem to think the answer is Government, so let us talk about Government overseeing health care. I can think of a few examples of the government's bad track record. We have the Indian health care in New Mexico and Oklahoma. There is an Indian hospital in Oklahoma right now that provides, I am going to say, pathetic service. And it happens to be bankrupt. We have had this problem, in addition to Medicaid and veterans hospitals and on and on and on. I mention that Government facilities, 100 percent Government-run facilities, are not the solution. It is probably some of the poorest quality of health care, not the best quality of health care. We want to improve quality, not reduce quality.

Some of the Nation's leading health care facilities today are expressing their concerns about Government oversight. I am thinking of the Mayo Clinic, Baylor Health Care System, and the Cleveland Clinic. They are all raising their voices in opposition to more Federal regulation of health care quality. I would like to share with my colleagues a few of their comments. I will ask unanimous consent that their letters be printed in the RECORD following my statement.

Baylor Health Care System—I will just read a couple of the paragraphs. It says:

> There has been an enormous commitment on the part of Baylor Health Care System and providers throughout the country to evaluate and put in place the processes for continuous quality improvement. We believe it must be done at this level. Providers of care are in the unique position, based on their personal commitment to the well-being

of the individual patient, to drive quality improvement initiatives. Nothing could stifle innovation quicker than external mandatory standards.

* * * * *

We strongly believe that the private sector is heavily committed and working very diligently on continuous quality improvement and that this will bring about the best outcome for the patients and communities we serve.

The Cleveland Clinic—one paragraph says:

Second, we are already subject to extensive federal, state and private regulations through oversight by private payors and accrediting bodies. Adding yet another layer of regulation will only further complicate matters, add administrative costs to our organization, and in all likelihood have little or no effect on the actual quality of care provided.

Dr. Bob Waller of the Mayo Clinic has stated:

Quality is a continuous process that must be woven into the fabric of how we think, act and feel. Government regulation places a stake in the ground that freezes in place a quality standard that may become obsolete very quickly. The Government simply cannot react quickly to the changing quality environment. The goal of quality is to continuously improve patient care—not to achieve some defined regulatory standard.

On January 28, several organizations—including the Joint Commission on Accreditation of Health Care Organizations, the National Committee for Quality Insurance and the American Medical Association—sent a letter to the President and Republican leadership stating their concern and opposition to the Federal Government preempting the private sector and creating new Federal agencies and entities. Specifically, they said quality would:

* * * become hamstrung by political considerations, with the practical effect of retarding innovation and advance in the field of accreditation and performance measurement. In our experience, the private sector is more capable of keeping pace with the rapid changes in health care delivery and medical practice that affect quality of care considerations. Therefore, we cannot support proposals that might have the unintended effect of undermining marketplace incentives for rigorous accreditation programs and robust performance measures.

Mr. President, I don't think the Government is the best caretaker of health care quality. I'm much more inclined to trust the independent organizations like the Joint Commission on Accreditation of Health Care Organizations and the National Committee for Quality Insurance. Because the Government alternatively leaves oversight to the folks at the Department of Labor and the Health Care Finance Administration—who, I might mention, took 10 years to implement a 1987 law establishing new nursing home standards; who have not bothered to change the fire safety standards for hospitals since 1985; and—in a most egregious instance—who are running end-stage renal disease facilities under Medicare using 1976 health and safety standards.

I think the answer is plain. We will not and we must not create massive new bureaucracies that will harm health care quality.

We have a real challenge ahead. We have to figure out how we can best address the very real complaints and concerns of the American people while not rushing to pass legislation that will exacerbate the problems or create new problems altogether.

To that end, our majority leader has instructed me to take a hard, honest look at issues that affect health care quality. At his instruction, I have put together a health care quality task force to examine the problems in our current system. Senators ROTH, CHAFEE, COATS, COLLINS, FRIST, SANTORUM, HAGEL and myself will be working together to find real answers to hard questions.

I know some of my colleagues have introduced legislation and they have very good intentions. We want to work with those colleagues, but again we want to make sure that we don't pass legislation that increases health care costs, we want to make sure we don't pass legislation that will put millions of people into the uninsured category for the first time. That would be a real mistake, and we don't want to pass legislation that will increase bureaucracy and reduce quality health care.

Mr. President, we have a big challenge: We will ask what the real-life impact of proposals like PARCA and President Clinton's Consumer Bill of Rights has on cost and on coverage. What will it mean to quality? We will ask whether Americans, given the choice, would rather have cutting edge institutions like Johns Hopkins setting trends in health care quality or the folks at the Department of Labor, or the Health Care Finance Administration. We will ask whom Americans should trust to monitor health care quality. Should the Federal Government do it or independent organizations who have been studying the issue and setting the pace for many years?

It is incumbent upon us as elected leaders to address these questions fairly, honestly, openly, and with an eye toward what is best for the health of a nation and not what is politically expedient.

Our objective at the very minimum is to do this: Ensure that Congress in its haste to do good does not cause an increase in the cost of health insurance, that we do not pass legislation that will unintentionally force individuals to give up their coverage, and we want to protect consumer quality by ensuring that the best possible caretakers are monitoring the quality of your health care, and not bureaucrats at the Department of Labor or at HCFA.

Mr. President, I want to make something very clear. This Republican Congress will not hijack the quality of our Nation's health care for political gain. We will, however, thoroughly and thoughtfully debate this issue and ensure that Americans continue to enjoy the highest quality health care in the world.

I ask unanimous consent the letters previously mentioned be printed in the RECORD, in addition to a letter that is signed by the American Medical Accreditation Program, the Joint Commission on Accreditation of Health Care Organizations, and the National Committee for Quality Insurance.

There being no objection, the letters were ordered to be printed in the RECORD, as follows:

AMERICAN MEDICAL ACCREDITATION PROGRAM,

January 28, 1998.

Hon. DON NICKLES,
Senate Majority Whip and Assistant Majority Leader,
Washington, DC.

DEAR MAJORITY WHIP NICKLES: As the nation's leading independent health care accrediting organizations, we are writing to recommend an alternative approach to certain quality oversight provisions contained both in proposals now before Congress and in the preliminary recommendations of the Presidential Advisory Commission on Consumer Protection and Quality in the Health Care Industry.

First, we would like to commend both this Congress and the Commission for taking up the issue of health care quality and consumer protections. Our health care system continues to undergo dramatic change, and there is a pressing need to answer the public's concerns with better information, improved oversight, and increased choice. Critical to these efforts will be enhanced consumer protections, and all three of our organizations stand ready to work with this Congress and the Administration to see that this happens.

Separate from the issue of consumer rights and protections, however, is the attempt by some to preempt private sector accreditation and performance measurement activities with proposals that favor the creation of new federal agencies and entities. Because these proposed federal agencies and entities would be charged with establishing minimum criteria for accreditation and core sets of performance measures, we have a keen interest in their potential outputs. Our basic concern is that this output will become hamstrung by political considerations, with the practical effect of retarding innovation and advances in the field of accreditation and performance measurement. In our experience, the private sector is more capable of keeping pace with the rapid changes in health care delivery and medical practice that affect quality of care considerations. Therefore, we cannot support proposals that might have the unintended effect of undermining marketplace incentives for rigorous accreditation programs and robust performance measures. We believe that the work of accreditors should be highlighted and encouraged.

As an alternative to these new federal bureaucracies, we are intent on together developing a comprehensive quality measurement and reporting strategy that engages consumers and private and public sector purchases; minimizes duplication; and maximizes the incentives for organizations and individuals to undergo accreditation and report standardized performance information. Our organizations have recently engaged in some noteworthy collaborative efforts such as the National Patient Safety Foundation; the Joint NCQA–JCAHO Work Session on Protecting Patient Confidentiality in a Managed Care Environment; cross-representation on the AMAP governing body; and coordination among our respective performance measurement councils. We intend to build on these ventures and ones already ongoing with others to keep excellence in patient care our number one priority.

We believe the federal government should reward high quality health plans and providers. As the largest purchaser of health care services, the federal government must take a leadership role in value-based purchasing. The federal government is already benefiting from closer coordination with private sector accreditation bodies, and the Balanced Budget Act of 1997 contains provisions for even greater collaboration. However, in addition to using those private sector accreditation and performance measurement tools developed by organizations such as ours, the federal government must progressively adopt the posture of leading private-sector purchasers and insist on high quality care for the 67 million Medicare and Medicaid beneficiaries and the 9 million federal employees, retirees, and their dependents.

We appreciate your consideration, and stand ready to work with this Congress and the Commission to build upon the successes of private sector accreditation without interfering in the operation of a marketplace that has produced programs as rigorous as ours. Please do not hesitate to contact any of our offices.

Sincerely,

DENNIS S. O'LEARY, MD,
President, Joint Commission on the Accreditation of Healthcare Organizations.
MARGARET E. O'KANE,
President, National Committee for Quality Assurance.
RANDOLPH D. SMOAK, JR., MD,
Chair, American Medical Accreditation Program.

BAYLOR HEALTH CARE SYSTEM,
Dallas, TX, February 11, 1998.

Hon. DON NICKLES,
Assistant Majority Leader, U.S. Senate, Washington, DC.

DEAR SENATOR NICKLES: First, let me thank you very much for your leadership and for your commitment to health related issues, specifically the matter of quality health care.

There has been an enormous commitment on the part of Baylor Health Care System and providers throughout the country to evaluate and put in place processes for continuous quality improvement. We believe it must be done at this level. Providers of care are in the unique position, based on their personal commitment to the well being of the individual patient, to drive quality improvement initiatives. Nothing could stifle innovation quicker than external mandatory standards.

Quality improvement is the key strategic objective for Baylor Health Care System. An example is the creation of our Institute for Quality which is driven by the board of trustees, physicians and senior management and extends throughout our organization. On a community level, we are involved with the Dallas-Ft. Worth Business Group on Health in building quality initiatives.

We strongly believe that the private sector is heavily committed and working very diligently on continuous quality improvement and that this will bring about the best outcome for the patients and communities we serve.

Again, we appreciate your support and look forward to working with you on this important issue.

Sincerely yours,

BOONE POWELL, JR.,
President.

CLEVELAND CLINIC FOUNDATION,
Cleveland, OH, February 11, 1998.

Hon. DON NICKLES,
U.S. Senate, Washington, DC.

DEAR SENATOR NICKLES: The Cleveland Clinic Foundation, a not-for-profit health care organization devoted to patient care, education and research in care for the ill, has serious reservations about many of the bills now pending in Congress to regulate quality in health care delivery. Our reservations are twofold.

First, quality is an elusive matter to quantify. Individual's versions of quality may vary considerably from their perspective of the health care system. A physician's emphasis, for example, is on the content of the care provided; a patient may judge quality more by the process of care delivered. In both instances, the standards are in flux as both the quality and process are constantly changing in response to new learning and new ways of better relating to patients and their families.

Second, we are already subject to extensive federal, state and private regulations through oversight by private payors and accrediting bodies. Adding yet another layer of regulation will only further complicate matters, add administrative costs to our organization, and in all likelihood have little or no effect on the actual quality of care provided.

We would urge that Congress proceed cautiously as it begins its debate about whether federal authority should be expanded in this important but necessary complex area of patient care.

Sincerely,

FLOYD D. LOOP, M.D.

The PRESIDING OFFICER. Under the previous order, the Senator from New Mexico is recognized to speak up to 45 minutes.

Mr. DOMENICI. Mr. President, I may not use that 45 minutes. I expect five or six Senators to join me and they have given me their statements. If they do not come I will place their statements in the RECORD.

(The remarks of Mr. DOMENICI, Mr. CLELAND, Mr. DODD, Mr. COCHRAN, Ms. MIKULSKI, AND Mr. KEMPTHORNE pertaining to the introduction of S. Res. 176 are located in today's RECORD under ''Submission on Concurrent and Senate Resolutions.'')

Mr. BYRD addressed the Chair.

The PRESIDING OFFICER (Mr. HAGEL). The Senator from West Virginia is recognized.

Mr. BYRD. Mr. President, how much time do I have?

The PRESIDING OFFICER. The Senator has one hour.

Mr. BYRD. Mr. President, I ask unanimous consent that any time that I do not use of my hour be reserved for later in the day.

The PRESIDING OFFICER. Without objection, it is so ordered.

THE INTERMODAL SURFACE TRANSPORTATION EFFICIENCY ACT

Mr. BYRD. Mr. President, I rise to commend the members of the Committee on Environment and Public Works, and especially the distinguished chairman of the committee, my lovable colleague from Rhode Island, Senator JOHN CHAFEE, that old crusty New Englander, whom I greatly admire, for including some very important provisions in S. 1173, the Intermodal Surface Transportation Efficiency Act of 1997, or ISTEA II. In my statement today, I will focus on the important provisions in the committee-reported bill that will expedite the delivery of desperately needed transportation projects to the American people—that is, if we ever get the opportunity to debate and amend and adopt this important bill.

I think most members would agree that addressing environmental issues in this body in a strong bipartisan way is—to say the least—difficult. Yet, Senator CHAFEE has managed to accomplish what few Senators have been able to do—craft legislation that enjoys strong support from Senators on both sides of the aisle that would help put order and efficiency in the way transportation projects are reviewed by both state and federal agencies, and as a result, reduce the time it takes to plan a project by as much as three years.

The ISTEA bill as reported by the Environment and Public Works Committee, recognizes that every day counts when planning and constructing a highway or bridge in this country are undertaken. The problem that was addressed in S. 1173 is a serious one. It now takes ten years to plan, design, and construct a typical transportation project in this country. I am sure that if Senators contacted their own state transportation departments, they would be disturbed to find the number of transportation projects that are being delayed due to overlapping and often redundant regulatory reviews and processes. These delays increase costs and postpone needed safety improvements that would save lives. One of the lives it saves may be yours. Think about it. I can tell my colleagues that, in my state of West Virginia, these numerous regulatory reviews have delayed critical improvements to the two most dangerous segments of roadway in the state.

Why does it take so long to plan a project? These delays are occurring because the development of a transportation project involves multiple federal and state agencies evaluating the impacts of the project and possible alternatives, as required by the National Environmental Policy Act (NEPA). While it would seem that the NEPA process would establish a uniform set of regulations and procedures for the submission of documents nationwide, this has not been the case.

For example, the Environmental Protection Agency, U.S. Corps of Engineers, U.S. Coast Guard, U.S. Fish and Wildlife Service, and their companion state agencies each require a separate review and approval process, forcing separate reviews guided by separate regulations and requiring planners to answer separate requests for information. Moreover, each of these agencies issues approvals according to separate schedules. The result: the time period